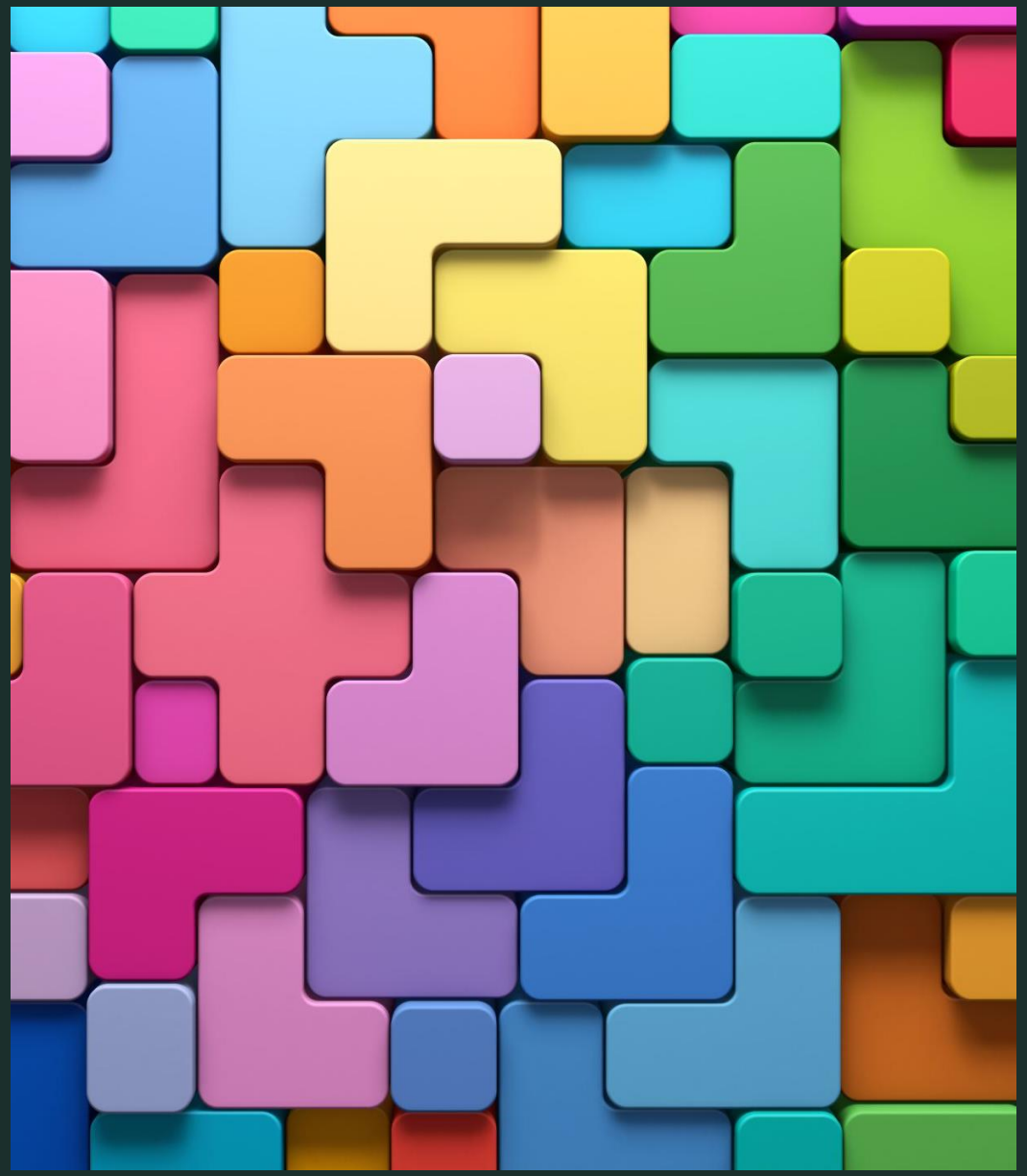
SDOH
HEALTH EQUITY
&
HEALTH LITERACY



A mindset for HH Assessment, Planning and Interventions

2024

Exhibit 8
Public

5 DOMAINS OF THE SOCIAL DETERMINANTS OF HEALTH

- Medical **care** is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population.
- The other 80 to 90 percent are sometimes broadly called the SDoH: health-related behaviors, socioeconomic factors, and environmental factors

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NEIGHBORHOOD AND BUILT ENVIRONMENT

- A windshield survey is an **observation tool used to assess the physical environment of a community**.
- It is performed by driving through the community and assessing the current condition of the environment, people, physical set up, and housing.
- Windshield surveys help identify health hazards and needs within the community and are essential in planning multidisciplinary interventions and programs that address these needs.

- Home Health Clinicians are uniquely poised for windshield assessments.
- This additional perspective can influence your patient assessment and care planning.
- Can you think of examples of how the patient's landscape, neighborhood and housing can impact a care plan created by your discipline?

  An easy example may be the home exercise program created by physical therapy.

EDUCATION ACCESS & QUALITY

- Health Literacy is linked to a person's health outcomes and can be impacted by:
- • Lack of context (limited experience with health care)
- • Stress and fatigue
- • Health conditions
- • Medications
- *Studies show that 9 out of 10 adults have difficulty understanding and acting on everyday health information that is provided to them in health care facilities, stores and the media.

Taking the time to ensure that your patient understands their medical condition, instructions and participates in their goals of care promotes improved health literacy.

- *Central Division Human Experience Communication Tool

HEALTHCARE ACCESS & QUALITY

- As a Providence Home Health Professional, you can evaluate the access and quality of a patient's healthcare options.
- Provide recommendations for services during care…

& at the time of discharge to a transitional service in the community.

SOCIAL AND COMMUNITY CONTEXT

The settings where patients live can impact their ability to access resources and obtain assistance.

Patients with positive relationships in their communities and places they live can improve health outcomes. As a home health clinician, you can identify key relationships and advocate for your patients to receive assistance from those they have a shared connection.

ECONOMIC STABILITY

Having more financial resources impacts housing, food, utilities, health insurance, no surprises here…health promotion is in the wheelhouse of our home health team.

- Provide resources for assistance programs.
- Medication adherence to prevent complications and hospital admissions.
- Healthy lifestyle education, motivational interviewing, patient centered goals.
- Chronic disease management to prevent complications.

PUTTING A PLAN IN ACTION: CASE STUDIES

Add 3-4 case studies to provide examples of SDOH interventions.

CASE STUDY #1

- 84 year old patient with primary hypertension being evicted from home in two weeks.
- Waitlisted for alternative housing for multiple section 8 housing options.
- Moved to a hotel with daughter who is a paid caregiver for the patient.

How do you think this situation impacts the patient's ability to manage their hypertension?

CASE STUDY #1 CONTINUED...

- After one month on home health service with SN, PT, OT, MSW and HHA, patient returned to the hospital with a BP of 184/75, increasing weakness, cognitive decline, deconditioning, frequent falls.

- Family reports that the patient's care needs are higher than what they can support.

- Discharged to a Skilled Nursing Facility with plans for placement in an adult foster home.

QUESTIONS TO CONSIDER...

- How does a sudden, unplanned change in housing impact chronic disease management?
- Would there be an emotional impact on this situation for the patient's daughter who is her primary caregiver?
- As this patient has been diagnosed with dementia, is a hotel a safe housing situation?
- In hindsight, are there other interventions that may have prevented rehospitalization?

CASE STUDY #2

- 58-year-old patient with lung cancer, type II DM,
- Living at home with 17-year-old son who is attending high school. Having trouble financially to pay for medical supplies. Has support from family, ride to care established. Shortness of breath limits tolerance to activity.
- MSW consulted and added to the team to establish LTC Medicaid services.

CASE STUDY #2 (CONTINUED)

- Identified needs from Social Work Intervention:
  - Financial concerns
  - Housing/ utilities
  - Food
  - Pet resources
  - Medical supplies

QUESTIONS TO CONSIDER:

- With multiple needs and a teenager, how does this impact the patient's ability to focus on her illness?
- The patient is offered PACE services through Providence, but if she accepts PACE, she will need to change oncologists. How do multiple siloed systems impact wrap around service plans?
- What are the downstream effects of financial constraints when dealing with a cancer diagnosis?

CASE STUDY #3

- 88 year old patient receiving home health physical and occupational therapy after a recent hospital stay for a fall and fractured wrist.
- At SOC, he scores 18 on the PHQ-9 indicating moderately severe depression.
- 4 months ago, the patients spouse passed away and he is living alone for the first time in his life, having purchased the home and raising a family there. He expresses that he is lonely and feeling isolated, many of his friends have passed away and his family lives on the other side of the state.
- Having identified the patient as depressed and isolated, the PT requests a HH MSW consult to evaluate for mental health and community resources. Reports the PHQ-9 to the referring provider.

CASE STUDY #3 (CONTINUED)

- MSW assessment and care plan includes:
- 1. supportive counseling
- 2. a referral to the local senior center to engage in social activities.
- 3. Involved patient's children in options for moving closer and exploring senior community living.

QUESTIONS TO CONSIDER:

- Was the patient's depression a factor in his fall?
- How does loneliness impact quality of life and interest in rehabilitative therapies?
- What factors of social and community context need to be considered in this case?

HP 2030
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Thank you!